<table>
<thead>
<tr>
<th>CLINICAL GUIDELINES ID TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title:</strong> Guideline for the cancellation of elective paediatric surgical patients</td>
</tr>
<tr>
<td><strong>Author:</strong> Kieran O’Connor</td>
</tr>
<tr>
<td><strong>Speciality / Division:</strong> Anaesthetics</td>
</tr>
<tr>
<td><strong>Directorate:</strong> ATICS</td>
</tr>
<tr>
<td><strong>Date Uploaded:</strong> 28/07/2014</td>
</tr>
<tr>
<td><strong>Review Date</strong> July 2020</td>
</tr>
<tr>
<td><strong>Clinical Guideline ID</strong> CG0006</td>
</tr>
</tbody>
</table>
Guideline for the cancellation of elective paediatric surgical patients with URTI

This guideline aims to set out clearly standards for criteria for the cancellation of elective paediatric surgery in Southern Health & Social Care Trust (SHSCT) due to Upper Respiratory Tract Infections (URTI).

Background

- Upper respiratory tract infection (URTI) occurs commonly in childhood with a reported frequency of 2-9 episodes per year in the normal child. Chronic nasal discharge, with similar features to URTI, is also common, particularly in a child who suffers from adenoidal hypertrophy.

- A history of URTI or other respiratory disease increases the risk of perioperative adverse respiratory events such as:
  - Coughing
  - Breath holding
  - Laryngospasm
  - Bronchospasm,
  - Airway obstruction,
  - Oxygen desaturation less than 90% (for 10 seconds or more)
  - Atelectasis,
  - Post-extubation stridor,
  - Pneumonia,
  - Unanticipated tracheal intubation or re-intubation.

- The risk of perioperative complications is greatest in the presence of acute infection but remains increased for 2-6 weeks after URTI. Airway reactivity is increased for up to 6-8 weeks following an URTI.

- Children undergoing major surgery may have increased perioperative complications, particularly infective complications. Most adverse perioperative events are easily manageable and have no lasting effect.

- Awareness of risk factors will guide the anaesthetist in deciding whether to proceed, and to tailor the anaesthetic to optimise the child’s condition.

‘Blanket’ cancellation may be the most conservative approach but it is not practical in the current environment of increasing caseloads and pressure to expedite surgery. It avoids complications but it increases emotional and economic burdens on parents.
The frequency of URTI experienced by the child should also be considered since it may be difficult to schedule the child during a symptom-free interval for elective surgery if he/she experiences 6-8 URTI episodes per year.

Assessment of child

Assessment of the suitability of any child with URTI symptoms for surgery is multifactorial and includes the:

- child’s age and presenting symptoms
- urgency and type of the procedure
- presence of co-morbidity.

Several factors need to be taken into account when evaluating a child for surgery.

- Those with mild symptoms of runny nose, sneeze, mild fever (<38 C) and mild cough could be considered for surgery particularly if the parent feels the child is generally well.

- Those with moderate to severe URTI with features of systemic illness with pyrexia and productive cough should be postponed to a later date.

A definite decision to postpone surgery would be when any of the following are present and the parents can be informed by telephone of this prior to coming to hospital-

- Child has croupy cough
- Lower respiratory tract symptoms such as wheezing/crepitations
- Systemic features of being unwell
  - Fever (Temp >38 C)
  - Malaise
  - Headache
- Active course of antibiotics prescribed by GP for systemic disease
- Abnormal chest X-Ray

*Any child who meets the above criteria on presentation for elective surgery should be postponed for 4 weeks*

Suggested algorithm for the assessment and anaesthetic management of the child with URTI

Dr K O’Connor (Paediatric Lead Anaesthetist CAH) May 2012
Fig 1: Suggested algorithm for the assessment and anaesthetic management of the child with URTI. Hx, history; TT, tracheal tube; LMA, laryngeal mask airway.

References

3. Schreiner MS, O’Hara I, Markakis D. Do children who experience laryngospasm have an increased risk of upper respiratory tract infection? Anesthesiology 1996; 85: 475–80